



ACUHEALTH

**AcuHealth Holistic Arts
366 South Main Street
Cheshire, CT 06410
203.439.7060**

Financial Policy Information

Policies: Please read and initial

_____ **Cancellations:** If you must cancel, I require the **courtesy of a minimum of 25 hours** notice. If you are unable to provide the required 25 hours notice, **there will be a \$60.00 charge**. Exceptions will only be made at my discretion in the case of emergencies.

_____ **Missed Appointments:** If the appointment is missed without a cancellation phone call, the patient will be charged the full cost of a visit.

_____ **Cancellations due to weather:** I will not charge for cancellations due to snow, however, appointments will not be canceled on the prediction of snow. If you choose to cancel on the prediction of snow, the 25 hour cancellation policy will apply. Please contact me on snow days before coming to an appointment (to make sure I will be at the office!)

_____ **Late for appointments:** Arriving for a scheduled treatment up to 20 minutes late the patient will be treated in the time remaining but will be charged the full rate. More than 20 minutes will be considered a missed appointment and *no* treatment will be given. The missed appointment policy will apply. If the patient is **repeatedly late, misses appointments or frequently reschedules or cancels on short notice**, I reserve the right to refuse further appointments.

_____ **Payment:** Payments and Co-pays will be expected at the time service is rendered unless patient has prepaid or is a Wellness Member. I accept cash, checks, Visa and MasterCard and Discover.

_____ **Insurance:** I accept Healthnet Insurance. For all other insurances, if your policy covers payment I will provide you with necessary documentation to file for reimbursement upon request. At this time with the exception of Healthnet, I do not verify coverage or submit claims.

_____ **Please be advised that not being able to leave work will not, under any circumstance, be considered an emergency.**

I have read and agree to the above policies and fees.

Signature of Patient _____

Date ___/___/___

Policy effective 6/1/2009